NON-CONFIDENTIAL

STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	EXHIBIT 19
	)	
DETERMINATION OF AGGREGATE	)	
MEASURABLE COST SAVINGS	)	PREFILED TESTIMONY OF
DETERMINED FOR THE SECOND	)	Steven Michaud, President
ASSESSMENT YEAR (2007)	)	Maine Hospital Association
	)	
	)	
	)	
	)	May 5, 2006

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Q. **Please state your name, position at the Maine Hospital Association and your responsibilities in that position.**

A. My name is Steven Michaud. I am the President of the Maine Hospital Association. The Maine Hospital Association represents all 39 community acute care and specialty hospitals in Maine and their affiliates.

Q. **And how long have you been in that position at the Maine Hospital Association?**

A. I have been the President for seven years and have been with the MHA since 1987.

Q. **Were you involved in the negotiations around the Dirigo Health legislation in 2003 and, if so, could you describe that involvement?**

A. Yes. The Maine Hospital Association was involved in negotiations with the Governor's Office, Legislative Leadership and other interest groups during the spring of 2003. We were involved in all phases of the negotiation, with much of our focus on the voluntary targets.

Q. **Could you describe your understanding of the voluntary limits for case mix adjusted discharge ("CMAD") established by the Dirigo Health legislation?**

A. Part F of the Dirigo Health legislation, enacted as Public Law 2003, c. 469, asked hospitals to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than 3.5% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004.

Q. **And to what time period were those limits applicable?**

A. The voluntary limits on hospital CMAD applied to hospital fiscal years beginning between July 1, 2003 and June 30, 2004. For example, if a hospital's fiscal year begins on October 1, it would have been asked to comply with the voluntary limit on

CMAD for its fiscal year beginning on October 1, 2003 and ending September 30, 2004. A copy of a letter from the Governor's Office evidencing this is attached to my testimony as Exhibit A.

Q. Did the Legislature or the Dirigo Health Agency establish any such voluntary limits for hospital fiscal years beginning between July 1, 2004 and June 30, 2005?

A. No.

Q. Were there voluntary limits established as the result of any other circumstances, outside of Dirigo Health?

A. Yes. In June of 2004, the MHA worked with our membership to set a voluntary 4.5% limit on increases in CMAD.

Q. Are you aware of any voluntary limits established prior to the existence of the Dirigo Health?

A. Yes. In 2002, the Maine Health Care Challenge asked hospitals and other health care providers in the Maine Health System to increase their prices by no more than 6% in 2003 and to hold operating margins to no more than 3% in 2003. A copy of a brochure describing the challenge is attached to my testimony as Exhibit B.

Q. Did the Dirigo Health Agency or any other representative of Maine State Government have anything to do with the 4.5% voluntary limit?

A. No. In fact, the Commission to Study Maine's Hospitals, in its February 2005 report to the legislature, recommended the continuation of the 3.5% voluntary limit because it was readily acknowledged that there was no target in the statute for the second Dirigo year.

Q. Did the MHA issue the press release at the request of the Dirigo Health Agency?

A. No.

Q. Was it ever MHA's intent or understanding that the DHA use the voluntary limits as a way to measure the aggregate measurable cost savings ("AMCS") for the SOP?

A. No. The voluntary limit was simply a voluntary 3.5% limit on hospital cost increases. We viewed any measurement activity as simply a comparison of the actual cost per CMAD in the voluntary limit year against the actual cost per CMAD in the prior year to see if a hospital actually complied with the voluntary 3.5% cost limit.

Q. Does a reduction in a hospital's Case Mix Adjusted Discharge ("CMAD") necessarily mean that the hospital's charges will be reduced?

A. No. It could result in a reduction in the rate of charge increaeses, but there are other factors that could also offset any reduction in hospital charges. Examples of this would be cuts in Medicare or Medicaid reimbursement, increases in the hospital tax, delayed Medicaid payments or any number of other factors.

Q. Can you briefly explain the Prospective interim payments or "PIPs" under MaineCare?

A. Periodic Interim Payments, or PIP payments, are weekly payments that are supposed to be based upon an estimate of volume for the year or quarter in which the payments are made. Medicare, Anthem, and most of the other payers do a fairly good job estimating what the volume will be and settle the difference quite quickly after the period ends. Anthem, for instance, settles quarterly. Medicaid is different, however. Recent expansions in Medicaid eligibility have resulted in PIP payments being

dramatically underestimated resulting in large receivables at almost every hospital in Maine.

Q. Did the Dirigo Health legislation address the PIP issue or require the State to either increase the PIP or accelerate the settlement?

A. No.

Q. In your opinion, are the PIP increases related to, or the result of, Dirigo Health?

A. No.

Q. Does an increase in PIP payments enable a hospital to decrease its charges?

A. In some cases it may result in a slight reduction in the rate of charge increases because of the cash flow impact that the lack of PIP adjustments has caused. Because the hospital has already established a receivable for this money, we have historically estimated that the reduction in charge increase may be 4% of the amount of the PIP increase. The 4% is based upon an average interest cost, which may be a bit higher now.

Q. Would reducing the "lag time" between the close of the hospital's fiscal year and the when the State actually pays the hospital enable a hospital to reduce its charges?

A. Again, the hospitals have already booked this reimbursement as a receivable so in some cases it would have no impact and in others it would only result in the slight reduction in the rate of charge increases that I described above.

Q. Does an increase in PIP payments increase a hospital's MaineCare reimbursement?

A. No. It changes only the timing of the payment.

Q. **Would an increase in MaineCare reimbursement rates enable a hospital to reduce the rate of charge increases?**

A. Yes, because it would reduce the cost shift to other payors.

Q. **Has there been such an increase in MaineCare reimbursement?**

A. No. In fact, there have been significant cuts to hospital reimbursements under MaineCare since Dirigo was enacted. There were cuts totaling $59 million in State Fiscal Year 2004-2005. Cuts in a hospital's MaineCare reimbursement require the hospital to increase its charges to other payors to make up for the lost revenue.

Q. **Is a significant portion of the revenue received by most hospitals in Maine received from public payors, such as MaineCare and Medicare, rather then private payors, such as health insurance carriers and self-funded plans?**

A. Approximately 50% of hospital revenue in Maine comes from public payors such as MaineCare and Medicaid, despite the fact that the individuals covered by those programs represent approximately 60% of utilization.

Q. **In your experience, is it fair to say that hospitals amend their letters of intent or applications for certificate of need ("CON") for a variety of reasons?**

A. Yes, hospitals often amend their letters of intent because things happen between when the letter of intent is submitted and the project is reviewed by CON staff. Examples of reasons that a hospital would amend its applications would be: the scope of the project changes, the cost of construction changes, or that technology and treatment practice simply advance during that period.

Q. **Isn't the cost of a certificate of need project embedded in a hospital's costs and, therefore, its CMAD?**

A. Yes, the operating costs of a project will eventually show up in the hospital's CMAD during the year in which the project becomes operational. Accordingly, the third year operating costs that are approved as part of the CON approved project would show up in the third year of operation.

Q. So wouldn't it follow that any modification in or elimination of a CON project that lowers or eliminates the project cost is embedded in a hospital's CMAD?

A. Any modification that lowers the operating cost of a CON approved project would begin to be seen in the hospital's CMAD calculation in the first year that the project begins to show actual operating costs. Accordingly, the third year operating costs that are approved in the application would eventually show up in the third year of operation.

Q. Does this conclude your testimony?

A. Yes.